Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

SERVICE CATEGORY:
MENTAL HEALTH SERVICES: ADULT
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Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2001 QIP initiative focused on adult/adolescent primary care and case management services, while FY 2002 focused on medically related care and care coordination. The following service categories were reviewed during FY 2002:

- Substance abuse treatment services
- Mental health services: adults
- Mental health services: children and adolescents
- Case management adherence
- Client advocacy
- Co-morbidity services

To assess the degree to which the Operational and Performance Standards for Mental Health Providers (Standards of Care) as established by the Greater Baltimore HIV Health Services Planning Council (Planning Council) were adhered to across the EMA, baseline data was gathered and analyzed from all Title I vendors in the EMA funded to provide the services listed above. Information presented in this report focuses exclusively on Adult Mental Health Services.

Section 1. Methodology

Process

The one to three day QIP reviews were conducted at 100% of six agencies providing Adult Mental Health Services. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

Consumer Survey: The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) general information about the consumer; b) services received; and c) level of involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys is summarized in a separate report.

Agency Survey: Agency surveys were completed by 100% of the vendors providing mental health services for adults. The tool is a self-report of how well the agency complies with the EMA's Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 4. (See Appendix C for a copy of the agency survey.)

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendors' adherence to the EMA's Standards of Care. The tool, which was reviewed by BCHD and the Planning Council, was developed by a content expert with demonstrated expertise in the area of mental health services. The tool contained items specifically relating to the Standards of Care, client demographics and descriptive items relating to service provision. (See Appendix B for a copy of the client chart abstraction tool.)

Time Frame

The review period focused on services provided in FY 2001 (March 1, 2001 to February 28, 2002) for Title I clients. Based on the number of clients reported receiving Mental Health services during FY 2001, vendors were instructed to randomly select a specific number of patient records who received services in the defined time frame. Recommendations for obtaining a random sample were provided. In addition, vendors were instructed to include approximately ten records that represent services initiated in FY 2001 and three to five closed records. From the vendor-selected records, the QIP reviewers selected a specified, smaller number of records to review for adherence to the Standards. For each client record reviewed, one chart abstraction instrument was completed.

The individuals conducting the QIP reviews had expertise in the service category being reviewed. Reviewers were trained in the QIP process, received written instructions for completion of the client chart abstraction instrument, participated in an orientation conference call, and were provided additional guidance as needed during the QIP review process. All completed client chart instruments were reviewed for completeness and consistency and responses were entered into a customized database for subsequent analysis.

Sample

A total of 913 clients were reported to have received services during FY 2001. A total of 186 Mental Health Services client records were reviewed at the six agencies, representing a total of 20.3% of all reported Title I clients. The number of records reviewed per site ranged from 10 to 44, with an average of 31 records reviewed per site (Table 1). The proportion of agency clients reviewed ranged from 16.5% to 64.7% of all reported Title I clients (Table 2).

Table 1. Mental Health Services agencies reviewed, dates of review and number of Mental Health Services client records reviewed

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
Anne Arundel County Department of Health	November 22, 2002	10	5.3%
Chase Brexton Health Services	October 7 – 9, 2002	37	19.8%
HERO	October 28 – 30, 2002	44	23.6%
Johns Hopkins University/Dept of Psychiatry	November 6 – 8, 2002	35	18.8%
Park West Medical Center	October 15, 2002	22	11.8%
University of Maryland	December 4 – 6 , 2002	38	20.4%
Total		**186**	**100%[1]**
Average		31	16.6%
Minimum		**10**	**5.3%**
Maximum		44	23.6%

[1] Note on all tables: Due to rounding, the total may not be equal to one hundred percent.

Table 2. Number of Mental Health Services clients and proportion of Mental Health client records reviewed

Agency Name	Reported # of Title I clients receiving Mental Health services	% of EMA total	% of agency's clients reviewed by QIP
Anne Arundel County Department of Health	33	3.6%	30.3%
Chase Brexton Health Services	200	21.9%	18.5%
HERO	252	27.6%	17.4%
Johns Hopkins University/Dept of Psychiatry	211	23.1%	16.5%
Park West Medical Center	34	3.7%	64.7%
University of Maryland	183	20.0%	20.7%
Total	**913**	**100%**	**20.3%**
Average	152	16.6%	28.0%
Minimum	**33**	**3.6%**	**16.5%**
Maximum	252	27.6%	64.7%

Section 2. Client Demographics

Gender and age

Of the sample of 186 clients, two-thirds (62.9%) were male and one-third (33.3%) female (Table 3). Four clients were transgender. One-half of clients (50%) were age 40-49 years (Table 4). The mean age of clients was 42.8 years, with men being slightly older than women, 43.2 years and 42.2 years, respectively.

Table 3. Gender distribution

Gender	n=186
Female	62 (33.3%)
Male	117 (62.9%)
Transgender	4 (2.2%)
Not documented	1 (0.5%)
Missing/Not abstracted	2 (1.1%)

Table 4. Age distribution

Age	n=186
13 – 19 years	1 (0.5%)
20 –29 years	5 (2.7%)
30 – 39 years	54 (29%)
40 – 49 years	93 (50%)
50 – 59 years	28 (15.1%)
60 – 69 years	3 (1.6%)
>70 years	--
Not documented	2 (1.1%)
Mean age (n=184) Min 18.5 years Max 66.3 years	42.8 years
Mean age Male (n=116) Min 18.5 years Max 66.3 years	43.2 years
Mean age Female (n=62) Min 27.5 years Max 60.3 years	42.2 years
Mean age Transgender (n=4) Min 33.4 years Max 39 years	37.2 years

Race/ethnicity

Of the population, almost seventy-percent (69.9%) of clients were African-American and one-quarter (24.7%), White. Of the females, African-Americans comprised 82% of the sample (Table 5). For males, African-Americans comprised 63% and Whites 30.8%, respectively (Table 6).

Table 5. Race/ethnicity distribution

Race/Ethnicity	n=186
African-American	130 (69.9%)
White	46 (24.7%)
Other	3 (1.6%)
Hispanic	2 (1.1%)
Not documented	5 (2.7%)

Table 6. Race/ethnicity distribution by gender

Race/Ethnicity	Male	Female	Transgender	Not documented /Missing	Total (% of row)
African-American	74 (63.2%)	51 (82.3%)	4 (100%)	1 (33.3%)	**130 (69.9%)**
White	36 (30.8%)	9 (14.5%)	—	1 (33.3%)	**46 (24.7%)**
Hispanic	2 (1.6%)	—	—	—	**2 (1.1%)**
Other	3 (2.6%)	—	—	—	**3 (1.6%)**
Not documented /Missing	2 (1.7%)	2 (3.2%)	—	1 (33.3%)	**5 (2.7%)**
Total % of column)	**117 (100%)**	**62 (100%)**	**4 (100%)**	**3 (100%)**	**186 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Transmission risk

Injection drug use (IDU) was the most frequently documented risk factor (30.6%), followed by MSM (14%) and heterosexual transmission (13.4%) (Table 7). Risk factor was not documented in 28% of the records reviewed. Men and women had similar proportion of IDU and "not documented" risk status (Table 8).

Table 7. Risk factor distribution

Risk Factor	n=186
IDU	57 (30.6%)
MSM	26 (14%)
Heterosexual	25 (13.4%)
IDU and Heterosexual	15 (8.1%)
MSM and IDU	5 (2.7%)
Undetermined/Unknown	2 (1.1%)
Other	2 (1.1%)
Hemophilia/coagulation	1 (0.5%)
Not documented	52 (28%)
Missing/Not abstracted	1 (0.5%)

Table 8. Risk factor distribution by gender

Risk Factor	Male	Female	Transgender	Not documented /Missing	Total (% of column)
IDU	38 (32.5%)	19 (30.6%)	—	—	**57 (30.6%)**
MSM	24 (20.5%)	—	1 (25%)	1 (33.3%)	**26 (14%)**
Heterosexual	7 (6%)	18 (29%)	—	—	**25 (13.4%)**
IDU and Heterosexual	6 (5.1%)	8 (12.9%)	1 (25%)	—	**15 (8.1%)**
MSM and IDU	5 (4.3%)	—	—	—	**5 (2.7%)**
Other	2 (1.7%)	—	—	—	**2 (1.1%)**
Undetermined/Unknown	1 (<1%)	1 (1.6%)	—	—	**2 (1.1%)**
Perinatal transmission	—	—	—	—	—
Hemophilia/coagulation	1 (0.5%)	—	—	—	**1 (0.5%)**
Not documented /Missing	33 (28.2%)	16 (25.8%)	2 (50%)	2 (66.6%)	**53 (28%)**
Total (% of column)	**117 (100%)**	**62 (100%)**	**4 (100%)**	**2 (100%)**	**186 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Disease status, biological indicators and treatment status

One third (33.3%) of clients had an AIDS diagnosis (Table 9). HIV disease status was not documented in 18.8% of the records. CD4 values were documented for two-thirds of the patients (n=124). The mean CD4 value was 358.8/mm^3, with women having a higher mean CD4 than men. Eleven percent (11.3%) had a CD4 value which indicates severe immunological compromise (<50/mm^3), while 27.4% had CD4 values greater than 500/mm^3. Viral load values were documented for 59% of the patients. Thirty-percent (30%) had an undetectable viral load, while 29.1% had a viral load of greater than 20,000 c/ml.

Almost one-half (47.8%) of clients were documented being on HAART during the review period. Treatment status, however, was not documented for more than one-third of clients (35.4%).

Table 9. Disease status, CD4 and viral load values, and treatment status

Disease Status	n=186
CDC-Defined AIDS	62 (33.3%)
HIV-infection	83 (44.6%)
Deceased	6 (3.2%)
Not documented	35 (18.8%)
CD4 Distribution	**n=124**
‹50/mm3	14 (11.3%)
50 – 199/mm^3	23 (18.5%)
200 – 499/m m^3	53 (42.7%)
› 500/mm m^3	34 (27.4%)
TOTAL	**124 (100%)**
CD4 values were not documented for 61 (32.7%) and missing; not abstracted for 1 (‹1%) of all client records reviewed.	
Mean CD4 Values	
Mean CD4 (n=124)	358.8/mm^3
Mean CD4 Male (n=77)	353.8/mm^3
Mean CD4 Female (n=43)	373.9/mm^3
Mean CD4 Transgender (n=3)	382.6/mm^3
Viral Load Distribution	**n=110**
Undetectable	33 (30%)
1 – 999 c/mL	16 (14.5%)
1000 – 6,999 c/mL	16 (14.5%)
7,000 –19,999 c/mL	13 (11.8%)
20,000 – 54,999 c/mL	10 (9.1%)
› 55,000 c/mL	22 (20%)
TOTAL	**110 (100%)**
Viral load values were not documented for 74 (39.7%) and missing; not abstracted for 2 (1%) of all client records reviewed.	
Treatment Status	**n=186**
% documented on HAART at any time during review period	47.8%
HAART treatment status was not documented for 66 (35.4%) of all client records reviewed.	

Insurance status

Insurance coverage was documented at the beginning or first entry of the review period and at the end or last entry of the review period. At this first entry, the largest proportion of clients had Medicaid insurance. Nearly eleven percent (10.7%) had no insurance at the first entry. Of these 20 clients, 8 had obtained health insurance during the review period. Insurance was not documented for 16% of clients (Table 10).

Table 10. Insurance status

Insurance Status	First Entry
Medicaid	83
No insurance	20
MPAP	18
Medicare	18
MADAP	15
Private/Commercial	15
Veteran's Administration	3
Not documented	29
Missing/Not abstracted	3

Note: Multiple responses documented.

Residence

The most frequent ZIP code of client residence was 21218, followed by 21201 and 21215. ZIP code was not documented in 12 records (6.5%), but Baltimore was noted as the city of residence.

Table 11. Residence

ZIP Code/City	#/% of total
21218	20 (10.8%)
21201	16 (8.6%)
21215	16 (8.6%)
21217	14 (7.5%)
Baltimore (ZIP code not documented.)	12 (6.5%)
21213	11 (5.9%)
21216	11 (5.9%)
21223	11 (5.9%)
21202	7 (3.8%)
21229	7 (3.8%)
21206	4 (2.2%)
21207	4 (2.2%)
21230	4 (2.2%)
21205	3 (1.6%)
21225	3 (1.6%)
21093	2 (1.1%)
21203	2 (1.1%)
21208	2 (1.1%)
21212	2 (1.1%)
21222	2 (1.1%)
21224	2 (1.1%)
17109	1 (0.5%)
20211	1 (0.5%)
20716	1 (0.5%)
20723	1 (0.5%)
21009	1 (0.5%)
21012	1 (0.5%)
21037	1 (0.5%)
21040	1 (0.5%)
21044	1 (0.5%)
21060	1 (0.5%)
21074	1 (0.5%)

ZIP Code/City	#/% of total
21078	1 (0.5%)
21108	1 (0.5%)
21113	1 (0.5%)
21126	1 (0.5%)
21144	1 (0.5%)
21157	1 (0.5%)
21211	1 (0.5%)
21220	1 (0.5%)
21227	1 (0.5%)
21231	1 (0.5%)
21237	1 (0.5%)
21239	1 (0.5%)
21401	1 (0.5%)
21740	1 (0.5%)
21791	1 (0.5%)
21842	1 (0.5%)
Missing; not abstracted	2 (1.1%)
Residence not documented in record	2 (1.1%)
Total	**186 (100%)**

Comparison with Baltimore City EMA prevalence data[2]

In comparison with reported Baltimore City EMA HIV/AIDS prevalence, the sample of records reviewed is comparable in terms of gender, but less African-American and has a higher proportion of adults in the 40-49 year age range.

Table 12. Demographic comparison of client records reviewed with Baltimore City EMA prevalence

Population	Reviewed client records	Baltimore City HIV/AIDS prevalence
African-American	69.9%	89.0%
White	24.7%	9.9%
Adult Male (>13 years)	62.9%	62.7%
Adult Female (>13 years)	33.3%	37.3%
Ages 30 – 39 years	29%	30%
Ages 40 – 49 years	50%	42%
Ages 50 – 59 years	15%	15.6%

HRSA reporting categories

Client demographics by HRSA reporting categories are reported below.

Table 13. Proportion of client records reviewed by HRSA reporting category

Population	Reviewed client records
0 – 12 months	0%
1 – 12 years	0%
13 – 24 years	<1%
Women >= 25 years	33%
African-American/Female	27%
African-American/Male	40%

[2] Baltimore City Health Department, HIV Disease Surveillance Program, "Baltimore City HIV/AIDS Epidemiological Profile", Third Quarter 2002. Prevalence data on September 30, 2001 as reported through September 30, 2002.

Section 3. Client-level assessment of compliance with EMA standards of care

A. Initial Evaluation (Standard of Care 1.1)

Standard of Care 1.1 focuses on the key components of initial evaluations for clients referred for mental health services. As part of the initial evaluation, a client history, mental status exam, cognitive assessment, and laboratory findings are to be assessed. In addition, a multi-axial diagnosis and care plan are to be identified and established. Based on the findings, care is to be rendered in a manner consistent with practice guidelines. A total of 84 clients entered treatment for mental health services during the review period, representing 45% of the total sample (n=186). Table 14 outlines agency compliance with the various components of the initial evaluation.

Table 14. Assessment of compliance with Standard of Care 1.1

EMA Standard	Percent of reviewed charts meeting Standards	
Initial evaluation must be conducted prior to the initiation of treatment. [MH Standard1.1]	93%	(n=84)
Initial evaluation must be conducted by licensed mental health professional working as part of an interdisciplinary team. [MH Standard1.1]	100%	(n=84)
Inclusion of a psychiatrist on interdisciplinary team. [MH Standard1.1]	67%	(n=84)
Initial evaluation documents client history. [MH Standard1.1.a]	87%	(n=84)

Client history item	% included (n=73)
Chief complaint	97%
Behavior	97%
Past psychiatric history	92%
Family history	90%
Substance use history	89%
Social and personal history	86%
Medical history	78%
Current and recent medications	53%
Review of systems	47%
Premorbid personality	10%
Mean percent completeness of client history	**73%**

Only those client records with a client history (73 of 84) were included in the table above.

Initial evaluation documents mental status evaluation. [MH Standard 1.1.b]	87%	(n=84)

Mental status evaluation item	% included (n=73)
Mood and affect	97%
Appearance	96%
Behavior	96%
Talk	89%
Suicidal risk	78%
Perceptual disturbances	62%
Thought processes (associations, flight of ideas)	60%
Homicidal risk	55%
Abnormal beliefs	51%
Self attitude	29%
Vital sense	23%
Obsessions/compulsions, phobias and panic attacks	22%
Mean percent completeness of mental status evaluation	**63%**

Only those client records with a mental status evaluation (73 of 84) were included in the table above.

Initial evaluation documents cognitive assessment. [MH Standard 1.1.c	80%	(n=84)

Cognitive assessment item	% included (n=67)
Level of consciousness	85%
Orientation	79%
Insight	58%
Judgment	57%
Educational level and Fund of Knowledge	51%
Memory	49%
Language	33%
Reasoning ability	30%
Mini-Mental Status and Verbal Trails Test	7%
Mean percent completeness of cognitive assessment	**49%**

Only those client records with a cognitive assessment (67 of 84) were included in the table above.

Initial evaluation documents laboratory studies, as indicated. [MH Standard 1.1.d]	43%	(n=84)
Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation. [MH Standard 1.1.e]	60%	(n=84)
Development of plan of care with specific measurable treatment goals through the appropriate use of outcome assessment. [MH Standard 1.1.f]	66% 33% of treatment plans contained goals. 18% of treatment plans contained methods of outcome assessment. *29 records excluded. Only those with a treatment plan included.*	(n=84)

Documentation of input from patient/client in treatment care. [MH Standard 1.1.f]	53% *29 records excluded. Only those with a treatment plan included.*	(n=55)
Specified treatment plan adheres to recognized treatment guidelines for the diagnosis category being treated. [MH Standard 1.1.g]	89% *29 records excluded. Only those with a treatment plan included.*	(n=55)

Of the 84 clients who initiated mental health services during the review period, 93% had an initial evaluation completed (Standard 1.1). According to Standard 1.1, the initial evaluation must be conducted by a licensed mental health professional working as part of an interdisciplinary team. All of the initial evaluations were conducted by licensed mental health professionals. In most cases (79%), the evaluation was conducted by one clinician. More than half (51%) were conducted solely by a psychiatrist. The rest were conducted by social workers (23%), nurses (17%), psychologists (10%), and counselors (4%). For the remaining 16 cases (21%), a team (more than one provider) was used to perform the initial evaluation. Standard 1.1 defines a team as consisting of a psychiatrist and any of the following professionals: a psychologist and/or a social worker and/or a mental health clinical specialist nurse. Non-licensed providers may also provide services under the supervision of appropriately licensed providers. While Standard 1.1 states that a psychiatrist must be a part of the interdisciplinary team, only 67% of reviewed charts documented a psychiatrist's participation.

Initial evaluations are to be conducted within 10 working days of notification of the provider (Standard 2.3.a). Slightly more than one-half of the records, 54% documented the date of referral and date of completed evaluation. Of those, the average length of time to complete an evaluation was 19 calendar days.

Standard 1.1.a states that an initial evaluation must document a client history and specifies 10 items to assess. Seventy three of the 84 records (87%) contained a client history and consistently documented the chief complaint (97%), behavior (97%), past psychiatric history (92%), family history (90%), substance use history (89%), social and personal history (86%), and medical history (78%). Items with a low rate of completion included premorbid personality (10%) and review of systems (47%). On average, approximately 7 of the 10 assessment items were routinely documented as part of the completed client histories.

As part of the initial evaluation, a complete mental status evaluation should also be completed (Standard 1.1.b). Of the 84 records reviewed, 87% contained a mental status evaluation and consistently documented mood and affect (97%), appearance (96%), behavior (96%), talk (89%), and suicidal risk (78%). The following items had lower rates of completion: obsessions/compulsions, phobias, and panic attacks (22%), vital sense (23%), and self attitude (29%). A cognitive assessment was documented in 80% of the 84 records reviewed (Standard 1.1.c). As part of the cognitive assessment, the highest rates of completion were for level of consciousness (85%) and orientation (79%). The lowest rates of completion were noted for the Mini-Mental Status and Verbal Trails Test (7%) and reasoning ability (30%).

Laboratory studies, as indicated, were documented in the initial evaluation in 43% of the 84 records reviewed (Standard 1.1.d).

Standard 1.1.e states that an initial evaluation must document a multi-axial differential diagnosis leading to a final diagnostic formulation. Of the 84 records reviewed, 60% documented a multi-axial

differential diagnosis. The most five most frequent diagnoses for Axis I were depressive disorder, cocaine dependence, opioid dependence, and alcohol dependence. There were very few Axis II diagnoses documented in the client records (n=7). Of those, the most common were mental retardation (n=2) and personality disorder (n=2). Axis III diagnoses were primarily HIV/AIDS and hepatitis. For Axis IV, the diagnoses documented were problems with the primary support group and other psychosocial and environmental problems. Eighty eight percent (88%) of clients with a multi-axial differential diagnosis had a documented current Global Assessment of Functioning (GAF) on Axis V with scores ranging from 44-75. Few records contained documentation of the highest GAF in the previous 12 months documented. (See Appendix A for further description of client diagnoses.)

While care plans, with specific measurable goals, are to be developed for all clients after the initial evaluation (Standard 1.1.f), only 66% of the 84 records reviewed contained such care plans. Specific, measurable treatment goals were documented in one-third (33%) of the care plans and outcome assessment methods were documented in only 18%. Issues relating to the client's HIV-related care and/or status were addressed in less than a quarter (24%) of the care plans and other issues of concern to the patient, such as housing, employment and medical care, were addressed in 24% of the care plans. Standard 1.1.f also states that the care plan must include input from the client. This was documented in 53% of the care plans reviewed.

Individual/supportive psychotherapy was the most frequently prescribed modality of treatment (Table 15). Some care plans contained multiple modalities, mainly alcohol/substance abuse treatment or group therapy. In 15% of all plans of care, no treatment modality was specified.

Table 15. Modalities of treatment specified in the treatment plan

Treatment modality specified in treatment plan	#/(% of treatment plans) n=55
Individual/Supportive Psychotherapy	36 (66%)
Alcohol/Substance abuse treatment	6 (11%)
Group/Supportive	5 (9%)
Individual/Cognitive Behavioral Therapy	2 (4%)
Individual/Interpersonal Therapy	2 (4%)
Medication management	2 (4%)
Self-Help Group	1 (1%)
No treatment modality specified in care plan	8 (15%)

Note: Multiple responses documented.

In 89% of the 55 plans reviewed, the care plan was consistent with practice guidelines (Standard 1.1.g). In 3 cases, the modality of treatment specified was not appropriate or adequately comprehensive. In three other cases, a diagnosis was not indicated; therefore, a determination of appropriate treatment could not be assessed.

B. Follow-up care and treatment (Standard of Care 1.2)

As with the Initial Evaluation Standards (1.1), the Standard of Care 1.2 outlines a series of key activities related to the provision and monitoring of care and treatment over time. All records reviewed (n=186) were assessed for compliance with the Standards relating to follow-up care and treatment. Table 16 outlines compliance with these Standards.

Table 16. Assessment of compliance with Standard of Care 1.2

EMA Standard	Percent of reviewed charts meeting Standards
Documentation of treatment plan. [MH Standard 1.1f]	49% (n=186)
Documentation of frequency of visits. [MH Standard 1.2.a]	99% (n=186) of reviewed charts contained documentation of patient visits. 79% (n=186) of reviewed charts contained documentation of frequency of patient visits that is appropriate, based on the diagnosis, severity of need and treatment plan.
Documentation of provision of supportive and educational counseling at all visits. [MH Standard 1.2.b]	81% (n=186)
Documentation of provision of supportive and educational counseling regarding prevention of "HIV transmitting behaviors". [MH Standard 1.2.b]	2% (n=186)
Documentation of provision of supportive and educational counseling regarding "substance abuse". [MH Standard 1.2.b]	43% (n=186)
Documentation of provision of psychotropic medications under the supervision of a psychiatrist. [MH Standard 1.2.d]	68% (n=186)
	93% (n=126) of patients were receiving medications prescribed by a psychiatrist. *60 records were excluded. Only those patients receiving medication were included.*
Documentation of opportunity for patient to develop an ongoing relationship with the psychiatrist prescribing their psychotropic medications. [MH Standard 1.2.d]	64% (n=126) *60 records were excluded. Only those patients receiving medication were included.*
Documentation of monitoring of medications. [MH Standard 1.2.d]	73% (n=126) *60 records were excluded. Only those patients receiving medication were included.*

Methods of monitoring medications	#
Patient interview	91
Laboratory monitoring	14
Caregiver interview	12

Note: Multiple responses documented.

Documentation of medication side effect assessment. [MH Standard 1.2.e]

54% (n=126)

60 records were excluded. Only those patients receiving medication were included.

Methods of side effect assessment	#
Patient interview	68
Patient physical assessment	16
Laboratory monitoring	12
Caregiver interview	8

Note: Multiple responses documented.

Documentation of teaching patient about medications. [MH Standard 1.2.e]

29% (n=126)

60 records were excluded. Only those patients receiving medication were included.

Methods of patient teaching	#
1:1 teaching by health care team	34
Materials given to patient	1

Note: Multiple responses documented.

Teaching content	#
Importance of medication adherence	27
Common and potentially serious side effects of medications	23
Expected benefits of teaching	20

Note: Multiple responses documented.

Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment outcome assessment. [MH Standard 1.2.f]

(n=186)

48.4% of reviewed charts contained documentation of monitoring of progress toward treatment plan goal attainment.

Documentation of inclusion of patient in monitoring of treatment plan goal attainment. [MH Standard 1.2.f]

(n=186)

61.8% of reviewed charts contained documentation of inclusion of patient in monitoring of treatment plan goal attainment.

Documentation of treatment plan reassessment at least every three months. [MH Standard 1.2.g]

8% (n=74)

112 records were excluded. Only 91 records of the reviewed records contained a treatment plan. Of these, 17 were excluded from analysis because they received services for less than three months are were not expected to have a reassessment.

Formal treatment plans were documented in 49% of the 186 records reviewed (Standard 1.1.f). Documentation of patient visits was contained in 99% of the records reviewed. Standard 1.2.a indicates the visit frequency should be based on the diagnosis, severity of need, and the treatment plan. Patients with active symptoms should be seen every one to two weeks while clients whose symptoms are in remission but remain on psychotropic medications should be monitored every 3 months. Of the records reviewed, 79% documented appropriate visit frequency (Standard 1.2.a).

Supportive and educational counseling at all visits is documented in 81% of the records reviewed (Standard 1.2.b). The Standard further specifies that this should include counseling, as clinically indicated, regarding prevention of HIV-transmitting behaviors and substance abuse. Only 2% of records documented any HIV prevention counseling. Substance abuse counseling was documented in 43% of the records reviewed (Standard 1.2.b).

Standard 1.2.c. refers to the various modalities of treatment appropriate for the Standard's target population. This information was collected only for those clients with an initial intake evaluation and care plan. This information is described above in Table 15.

Standards 1.2.d and 1.2.e focus on the prescription and monitoring of appropriate medication as indicated by the clinical situation, evidence-based practice guideline recommendations, and linkage to specific treatment guidelines. Standard 1.2.d states that psychotropic medications must be provided under the supervision of a psychiatrist. More than two-thirds of the records reviewed (68%) indicated that medications were prescribed by the mental health provider, and 93% of the time were prescribed by a psychiatrist. Other prescribers include a physician (5%) and a physician assistant (1%).

For the clients prescribed medication, 73% of the records contained documentation of routine and appropriate monitoring of medications under the supervision of a psychiatrist. The methods used to monitor the medications include patient interviews, laboratory monitoring, and caregiver interviews. Standard 1.2.d states that the patient/client must have the opportunity to develop ongoing relationships with the psychiatrist(s) prescribing their psychotropic medications. Almost two-thirds of the records reviewed (64%) meet this Standard.

Standard 1.2.e addresses side effect management and medication teaching for clients. Of the records reviewed, 54% of the records documented routine and appropriate side effect management for clients receiving psychotropic medications. The methods used to assess side effects included patient interviews, physical assessment of the patient, laboratory monitoring, and caregiver interviews.

Fewer records contained documentation related to medication teaching. Less than a third (29%) of the records contained documentation that patients had received teaching about their medications. All but one of those patients had received one-to-one teaching by the health care team. One person also received written materials. Content documented in the record included the expected benefit of medications, common and potentially serious side effects of medications, and the importance of medication adherence.

Standard 1.2.f focuses on monitoring the patient's progress towards treatment goals through the use of appropriate outcome assessments, which must include input from the client. Of the 186 records reviewed, less than half (48%) documented the use of outcome assessments to monitor progress toward treatment goals. Further analysis shows that clients with treatment plans (61%) were more likely to have monitoring/assessment documented than those without care plans (38%).

More than half (52%) of the records reviewed indicated that the client was making progress towards treatment goal attainment. For 39%, the lack of progress was documented by the mental health provider (Standard 1.2.f). Barriers to progress and issues identified included non-adherence with medication/treatment (24%), change in patient stressors (9%), lack of medication tolerability (5%), inadequate dosage (5%), and medical co-morbidity (4%). Other barriers (13%) that were specified included alcohol and substance abuse, lack of follow-up, changing medications, and interpersonal skills.

Patient inclusion in monitoring/assessment of progress towards treatment goals was documented in 62% of the 186 records reviewed (Standard 1.2.f). Patients who had a care plan were more likely to be

included in monitoring. For the 91 records that contained a care plan, 70% documented patient involvement.

Standard 1.2.g outlines a 3-month time interval for reassessment of the treatment plan and assessment of progress made towards goal attainment. Of the 74 records that contained a treatment plan and were eligible for reassessment every three months, **only 8% (n=6) of records documented reassessment.**

Termination and Discharge Planning

There are no specific standards regarding termination and discharge planning. Of the 186 charts reviewed, 80% of clients continued to receive services through the end of the review period. Thirteen percent of clients (n=24) did not continue in care. Patient status was not documented in 7% of the records reviewed. Of those that did not continue to receive services, three clients completed care and 21 were terminated by the provider. Reasons for termination included non-compliance with treatment, patient death, transfer of care to another agency, entry into substance abuse treatment, geographic move, and violation of agency policy (Table 17).

Table 17. Reason for patient termination from Mental Health Services

Reason for termination	# (% of total)
Patient was not compliant with treatment	9 (43%)
Patient death	5 (24%)
Care transferred to another agency	3 (14%)
Patient entered substance abuse treatment	1 (5%)
Patient moved	1 (5%)
Patient violated agency policy	1 (5%)
Reason not documented	1 (5%)
Total	**21 (100%)**

Additional data were collected regarding discharge planning and continuity of care. Less than half (42%) of the charts reviewed documented appropriate discharge planning for clients and only a quarter (25%) documented the inclusion of the client in the discharge planning.

Section 4. Agency-level assessment of compliance with EMA standards of care

As part of the QIP process, agencies providing adult mental health services were asked to complete a six page survey (See Appendices for a copy of the instrument). The purpose of this survey was to document the self-reported compliance with the EMA's Operational and Performance Standards for Mental Health Providers pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses.

Table 18 lists the services directly provided by the agencies delivering mental health care to adults and those provided through referral agreements. The 6 agencies provide a large number of other services to clients and range from ambulatory health care to ancillary and supportive services, such as transportation and direct emergency assistance. The agencies also report having access to a wide array of services through referral agreements. While several agencies provide direct services for ambulatory care (50%) and for substance abuse treatment (67%), these two categories of services are also provided by referral from agencies (67% for each category).

Table 18. Services provided directly by Mental Health agencies or through referral agreements.

Service category (n=6)	% which provide service directly	% with referral agreements
Mental Health Services	100%	0%
Case Management	83%	17%
Counseling	83%	17%
Substance Abuse Treatment (SA)—Individual Counseling	83%	17%
Client Advocacy	67%	0%
Outreach	67%	0%
Transportation	67%	17%
Direct Emergency Assistance	67%	17%
Substance Abuse Treatment	67%	67%
Case Management Adherence	67%	0%
Ambulatory Health Care	50%	67%
Viral Load Testing	50%	33%
Food/Nutrition	50%	33%
Dental Care	50%	17%
Co-Morbidity Services	50%	17%
SA- Group Counseling	50%	0%
Housing Assistance	33%	33%
Legal Services	33%	17%
Buddy/Companion	17%	0%
SA-Inpatient Detoxification	17%	33%
SA-Outpatient Detoxification	17%	33%
SA-Long-term Structured Program	17%	50%
SA-Methadone	17%	33%
SA-12-Step Programs	17%	33%
Enriched Life Skills	17%	0%
SA-LAMM	0%	17%

A. Licensing, Knowledge, Skills and Experience (Standard of Care 2.1)

All agencies report 100% compliance with standards relating to staff licensing, knowledge, skills, and experience (Standard 2.1) (Table 19).

Table 19. Agency-level assessment of compliance with Standard of Care 2.1

EMA Standard	Percent of agencies reporting compliance Standard	
All staff delivering mental health services will possess current organizational and professional licensure. (Standard 2.1.a)	100%	(n=6)
Non-licensed staff or trainees delivering mental health services will receive professional supervision, of the care they are providing to individual patients/clients, by a licensed mental health provider. (Standard 2.1.b)	100% *2 agencies indicated that this standard was not applicable and were excluded from analysis.*	(n=4)
All staff delivering mental health services will either have specific experience in caring for HIV infected patients or receiving appropriate training. (Standard 2.1.c)	100%	(n=6)

B. Patient Rights and Confidentiality (Standard of Care 2.2)

Standards 2.2.a and 2.2.b both address policies and procedures relating to patient rights. Of the 6 agencies surveyed, 67% report compliance with policies and procedures relating to confidentiality (Standard 2.2.b) and 67% indicate that they have policies and procedures regarding the provision of culturally appropriate care to their patients (Standard 2.2.c) (Table 20). For the four agencies in compliance with Standard 2.2.c regarding culturally appropriate care, 100% compliance is reported for the section of the Standard requiring the providers to have training or experience with caring for those groups most affected by the epidemic, such as gay men, African-Americans, and substance abusing persons. Eighty four percent of the agencies reported they are in compliance with Standard 2.2.d which states that the provider organization will provide assurances that mental health services will be provided regardless of the sexual orientation of the clients/patients. There is 100% compliance with Standard 2.2.e stating that if unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific licensed providers.

Table 20. Agency-level assessment of compliance with Standard of Care 2.2

EMA Standard	Percent of agencies reporting compliance Standard	
The provider organization will provide assurances and a method of protection of patient rights in the process of care provision. (Standard 2.2.a)	67%	(n=6)
The provider organization will provide assurances and a method of protection of patient confidentiality (in accordance with Maryland Annotated Code) with regard to medical information transmission, maintenance and security. (Standard 2.2.b)		

The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients/clients. Specifically, the providers must have training or experience with caring for those groups most affected by the epidemic, such as: gay men, African-Americans, and substance abusing persons. (Standard 2.2.c)	67% ▪ gay men (100%; n=4) ▪ African-Americans (100%; n=4) ▪ Substance abusing persons (100%; n=4)	(n=6)
The provider organization will provide assurances that mental health treatment services will be provided regardless of the sexual orientation of the client/patients. Respect, confidentiality, and equal access will be assured. (Standard 2.2.d)	84%	(n=6)
If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific licensed providers. (Standard 2.2.e)	100% *2 agencies indicated that this standard was not applicable and were excluded from analysis.*	(n=4)

C. Access, Care and Provider Continuity (Standard of Care 2.3)

Agencies report a high degree of compliance with standards relating to access, care and provider continuity (Table 21). Standard 2.3.a states that the provider organization must provide clinical services in a timely fashion to all patients/clients. Eighty four percent (84%) of agencies are in compliance with the section of the standard requiring that emergencies must be addressed within 2 hours of notification of the provider.

Eighty four percent (84%) of agencies are in compliance with the section of the standard stating that new patient/client evaluations will generally be conducted within 10 working days of notification of the provider. However as noted above (Section 3.A), the client record review indicates that the average length of time to complete an evaluation was 19 calendar days. One hundred percent (100%) of agencies report they are in compliance with the section of the standard stating that providers must consider providing access to their staff on a 24-hour basis; 66% report providing this access.

One hundred percent (100%) of agencies report they provide mechanisms for urgent care evaluation or triage (Standard 2.3.b).

Standard 2.3.c deals with access to a range of mental health services, including: day programs, day hospitals, and inpatient psychiatric units. Eighty four percent (84%) of the agencies report they are in compliance with the standard.

High rates of compliance were reported for Standard 2.3.d. which deals with the provider organization's mechanisms for continuity of mental health/psychiatric care to their patients/clients in all settings in which they may receive care, including [but not limited to]: day programs (84%), day hospitals (84%), substance abuse programs (100%), inpatient psychiatric units (84%), inpatient medical units (84%), and chronic care units (84%). One hundred percent (100%) of the agencies reported they were in compliance with the section of Standard 2.3.d which states that provision will be made for "off site" care if clinically necessary.

One hundred percent (100%) of the agencies indicate they will develop and maintain linkages with substance abuse treatment service providers in order to maintain continuity of care for patients with dual diagnoses of substance abuse disorders and other mental disorders (Standard 2.3.e).

Standard 2.3.f states that the provider organization will develop and maintain linkages with primary medical care service providers in order to maintain continuity of care for patients receiving primary or

specialty care. Eighty four percent (84%) of agencies report they are in compliance with the Standard as it applies to primary care. Fifty percent (50%) of agencies report compliance as it applies to specialty care.

Table 21. Agency-level assessment of compliance with Standard of Care 2.3

EMA Standard	Percent of agencies reporting compliance Standard	
The provider organization will provide clinical services in a timely fashion to all patients/clients. Emergencies must be addressed within 2 hours of notification of the provider. New patient/client evaluations will generally be conducted within 10 working days of notification of the provider. Providers must consider providing access to their staff on a 24-hour basis. (Standard 2.3.a)	✖ within 2 hours (84%) ✖ within 10 days (84%) ✖ consider 24 hours basis (100%)	(n=6)
The provider organization must provide mechanisms for urgent care evaluation or triage. (Standard 2.3.b)	100%	(n=6)
The provider organization will provide mechanisms to make available to its patients/clients access, if clinically indicated, to the full range of mental health treatment settings including: ✖ day programs ✖ day hospitals; and ✖ inpatient psychiatric units. (Standard 2.3.c)	✖ day programs (84%) ✖ day hospitals (84%) ✖ inpatient psychiatric units (84%)	(n=6)
The provider organization will provide mechanisms for continuity of mental health/psychiatric care to their patients/clients in all settings in which they may receive care, including [but not limited to]: ✖ day programs ✖ day hospitals ✖ substance abuse programs ✖ inpatient psychiatric units ✖ inpatient medical units ✖ chronic care units. Provision will be made for "off site" care if clinically necessary. (Standard 2.3.d)	✖ day programs (84%) ✖ day hospitals (84%) ✖ substance abuse programs (100%) ✖ inpatient psychiatric units (84%) ✖ inpatient medical units (84%) ✖ chronic care units (84%) ✖ off site care (100%)	(n=6)
The provider organization will develop and maintain linkages with substance abuse treatment service providers, so as to maintain care continuity for patients with dual diagnoses of substance use disorders and other mental disorders. (Standard 2.3.e)	100%	(n=6)
The provider organization will develop and maintain linkages with primary medical services providers, so as to maintain care continuity for patients receiving primary or specialty medical care. (Standard 2.3.f)	✖ Primary care (84%) ✖ Specialty medical care (50%)	(n=6)

D. Quality Improvement (Standard of Care 2.4)

High rates of compliance were reported for two of the three standards dealing with quality improvement. All of the agencies (100%) indicate they will provide for methods to monitor areas in need of improvement (Standard 2.4.a) (Table 22). All of the agencies report they will provide for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement (Standard 2.4.b). Eighty four percent (84%) of the agencies report compliance with

Standard 2.4.c, which states that utilization review decisions will be clinically based on best practice and consistent with emerging national standards. All of the agencies (100%) indicate they have a process for clients to evaluate the agency, staff, and services.

Table 22. Agency-level assessment of compliance with Standard of Care 2.4

EMA Standard	Percent of agencies reporting compliance Standard	
The provider organization will provide for methods to monitor for areas in need of improvement. (Standard 2.4.a)	100%	(n=6)
The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement. (Standard 2.4.b)	100%	(n=6)
Utilization review decisions will be clinically based on best practice and consistent with emerging national standards. (Standard 2.4.c)	84%	(n=6)

Section 5. Discussion

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of adult mental health providers (n=6) receiving Title I funds during FY2001. A total of 186 adult mental health records were reviewed, representing 20.3% of Title I adult mental health clients served in the Baltimore EMA.

The following items have a higher rate of compliance with the Standards of Care:

- Ninety-three percent (93%) of clients who initiated services during the review period had an initial evaluation completed. All (100%) of these assessments were conducted by a licensed mental health professional.

- Eighty-seven percent (87%) of records reviewed with an initial evaluation documented a client history and mental status examination and 80% documented a cognitive assessment.

- Seventy-eight percent (78%) of clients had visit frequencies that were appropriate based on diagnosis, severity of need, and treatment plan. Eighty-nine percent (89%) of the treatment plans (n=49) adhered to recognized treatment guidelines for the diagnosis category being treated.

- Eighty-one percent (81%) of the records reviewed documented that supportive and educational counseling was provided at all visits.

- All (100%) of the agencies provide a large number of services to clients in addition to mental health care. These services are provided directly and by referral.

- All (100%) of the agencies reported having a process for clients to evaluate the agency, staff, and services.

- Agencies reported 100% compliance with two out of the three Standards related to quality improvement. For the third Standard, 84% of agencies reported that utilization review decisions will be clinically based on best practice and consistent with emerging national standards.

This review of QIP data identifies several areas where there is a lower rate of compliance with the Standards of Care. The most notable areas are discussed below and include:

1. Initial client evaluation;
2. Development and reassessment of treatment plans;
3. Documentation of antiretroviral treatment and of laboratory values;
4. Patient counseling and teaching; and
5. Agency policies and procedures.

While 93% of clients initiating services had an initial evaluation conducted prior to the initiation of treatment, the comprehensiveness and completeness of these evaluations was highly variable. Client history, mental status examinations and cognitive assessments were documented in a large number of records; however, many of the specified components of these assessments were not routinely documented. Appropriate laboratory studies were documented in only 43% of initial assessments and a multi-axial differential diagnosis was documented in 60% of records. Of these, many lacked a complete diagnosis. While Standard 1.1 states that a psychiatrist must be a part of the interdisciplinary team, only 67% of reviewed charts documented a psychiatrist's participation. Standard 2.3.a indicates that client evaluations

should be conducted within 10 working days of notification of the provider, the review indicates that the average length of time is 19 calendar days.

Treatment plans were developed for 66% of those with an initial assessment, and few of these were in the format specified by the Standards. Only one-third (33%) contained specific, measurable treatment goals and 18% specified methods of outcome assessment to be used. Issues relating to the patient's HIV care and other issues of concern to the patient were addressed in only one-quarter (25%) of the treatment plans. Patient input was documented in slightly more than one-half (53%) of the developed treatment plans.

Slightly less than half (49%) of all the records reviewed documented formal treatment plans. Once in place, treatment plans were not routinely assessed as specified in the Standards. Only 8% of the records documented appropriate re-evaluation of the plan. It is interesting to note that clients with treatment plans were more likely to have monitoring and assessments documented than those without treatment plans.

Laboratory values specific to HIV care (CD4 and viral loads) and antiretroviral treatment status were documented in approximately two-thirds of the records. Although 81% of the reviewed records documented the provision of supportive and educational counseling, HIV prevention and substance abuse counseling were not routinely addressed. Only 2% of the records documented HIV prevention counseling and less than half (43%) documented substance abuse counseling.

Of the sample, 68% of the patients were prescribed medications. Of those, 73% of the records reviewed contained documentation of monitoring of medications and 54% documented side effect assessment. Patient teaching was documented in only 29% of the records.

While all of the agencies report 100% compliance with all of the Standards relating to agency policies and procedures regarding licensing, knowledge, skills and experience, only 67% of the agencies report compliance with policies and procedures relating to confidentiality and provision of culturally appropriate care to their patients. Five of the six agencies (84%) reported they provide assurances that mental health services will be provided regardless of the sexual orientation of the clients/patients.

Compliance with Standards relating to access, care, and provider continuity generally range between 84% and 100%. The one exception is the 50% compliance rate reported for the Standard dealing with development and maintenance of linkages with primary medical care service providers in order to maintain continuity of care for patients receiving specialty care.

Section 6. Recommendations

The primary recommendations for Adult Mental Health Services focus on three areas: 1) priority areas for quality improvement projects; 2) review and revision of the Standards of Care; and 3) development of quality indicators for Adult Mental Health Services.

Priority Areas for Quality Improvement Projects
As previously identified, the most notable issues related to the provision of Adult Mental Health Services focus on five main areas: 1) initial client evaluation; 2) development and reassessment of treatment plans; 3) documentation of antiretroviral treatment and of laboratory values; 4) patient counseling and teaching; and 5) agency policies and procedures. As the EMA and individual vendors identify quality improvement projects to undertake, these five areas can be incorporated into these projects.

Review and Revision of the Standards of Care

As an initial step in the quality improvement process, it might be beneficial to review the Standards of Care to clarify the minimum expectations of service delivery, identify components that are not currently addressed and revise them as appropriate. Within the currently published Standards, specific examples of items that are not currently addressed in the Standards include the following: 1) discharge planning; 2) documentation of failed/cancelled or missed appointments; 4) follow-up of clients lost to care; and 4) policies and procedures for termination or closing of cases.

The Standards should also specify the client-level data providers should be expected to document not only as part of the initial assessment but also to regularly update. These include:

- HIV-transmission risk
- CD4 value
- Viral load
- Current medications, including antiretroviral therapy
- Current primary medical care provider
- Case manager/case management agency
- Insurance status

Additionally, it may be beneficial to expand the routine reporting requirements to include type of treatment modalities provided and more client-specific utilization data that can be used to monitor trends.

The Standards should be reviewed and revised in conjunction with review the document, "Standards of Care Comparative Analysis: Mental Health" which was completed in December 2002 as part of BCHD's Quality Improvement Program. This report provides an analysis of the current Standards and a comparison of these Standards with three other established Standards of Care for mental health services.

Quality Indicators

As the Standards are revised, incorporation of quality indicators is integral to the quality improvement process. By identifying the core indicators to track and trend, the expectations regarding service delivery are further clarified. Based on the review of the Standards and the data collected as part of the QIP review process, the recommended core quality indicators to track as part of Adult Mental Health Services are identified in Table 23. Target performance goals have also been identified in this table, but the actual goal should be finalized in conjunction with BCHD and the Planning Council.

Table 23. Recommended Quality Indicators for Adult Mental Health Services

Quality Indicator [Reference]	EMA Mean Performance	Performance Goal
% of client records which document completion of initial evaluation by a licensed mental health professional, working as part of an interdisciplinary team prior to the initiation of treatment. [Standard 1.1]	93%	90%
% of client records which document completion of multi-axial differential diagnosis leading to final diagnostic formulation. [Standard 1.1.e]	60%	80%
% of client records which document completion of treatment plan [with specific measurable treatment goals through the appropriate use of outcome assessment] [Standard 1.1.f]	66%	90%
% of client records which document reassessment of the treatment plan and progress every three months. [Standard 1.2.g]	8%	80%
% of client records which document medication side effect assessment and teaching for patients on psychotropic medications. [Standard 1.2.e]	54%	80%

Appendices

- Appendix A. Summary of Multi-axial Diagnoses
- Appendix B. Client Chart Abstraction Instrument: Mental Health Services: Adult
- Appendix C. Agency Survey: Mental Health Services: Adult
- Appendix D. Operational and Performance Standards for Mental Health Providers, ratified October 1997; reviewed September 1999. Greater Baltimore HIV Health Services Planning Council. http://www.baltimorepc.org

Appendix A. Summary of Multi-axial diagnoses

While 50 (60% of the records reviewed) of the clients had a multi-axial differential diagnosis (Standard 1.1.e), 20 additional clients had only a documented Axis 1 diagnosis. A total of 70 clients had a documented Axis 1 diagnosis. Of these, 33% had one Axis 1 diagnosis, 36% had two Axis 1 diagnoses, 23% had three Axis 1 diagnoses, and 8% had four or more Axis 1 diagnoses. Table below shows the frequency of diagnosis by Axis.

Frequencies of Axis 1 diagnoses

#	DSM-IV Code	Axis 1 Diagnosis
20	311	Depressive Disorder NOS (Not otherwise specified)
16	304.2	Cocaine Dependence
12	304	Opioid Dependence
10	304.8	Polysubstance Dependence
9	303.9	Alcohol Dependence
8	309	Adjustment Disorder With Depressed Mood
8	296.3	Major Depressive Disorder, Recurrent, Unspecified
7	305	Alcohol Abuse
6	296.8	Bipolar Disorder NOS
4	296.32	Major Depressive Disorder, Recurrent, Moderate
3	V71.09	No Diagnosis on Axis I
3	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
3	294.9	Cognitive Disorder NOS
3	300.01	Panic Disorder Without Agoraphobia
3	309.81	Posttraumatic Stress Disorder
2	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
2	291	Alcohol Withdrawal Delirium
2	296.4	Bipolar I Disorder, Most Recent Episode Hypomanic
2	305.6	Cocaine Abuse
2	296.9	Mood Disorder NOS
2	298.9	Psychotic Disorder NOS
1	V62.3	Academic Problem
1	309.9	Adjustment Disorder Unspecified
1	309.24	Adjustment Disorder With Anxiety
1	291.8	Alcohol Withdrawal
1	301.7	Antisocial Personality Disorder
1	300	Anxiety Disorder NOS
1	V62.82	Bereavement
1	296.6	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
1	294.1	Dementia Due to Head Trauma
1	302.85	Gender Identity Disorder in Adolescents or Adults
1	312.34	Intermittent Explosive Disorder
1	296.36	Major Depressive Disorder, Recurrent, In Full Remission
1	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
1	995.5	Neglect of Child (if focus of attention is on victim)
1	300.21	Panic Disorder With Agoraphobia

1	295.9	Schizophrenia, Undifferentiated Type
1	304.1	Sedative, Hypnotic, or Anxiolytic Dependence
1	300.23	Social Phobia

A noted above, few of the clients with a multi-axial diagnosis had an Axis 2 diagnosis.

Frequencies of Axis 2 diagnoses

#	DSM-IV Code	Axis 2 Diagnosis
23	799.9	Diagnosis deferred on Axis 2
17	V71.09	No diagnosis Axis 2
3		Not documented
2	319	Mental retardation
2	301.9	Personality disorder
1	V62.89	Borderline intellectual functioning
1	301.83	Borderline personality disorder
1	301.7	Antisocial personality disorder
1		Missing/not abstracted

HIV/AIDS and hepatitis were the most frequently documented Axis 3 diagnoses.

Frequencies of Axis 3 diagnoses

#	Axis 3 Diagnosis
47	HIV/AIDS
13	Hepatitis
4	Asthma
2	Arthritis
1	Alopecia
1	Anemia
1	Ataxia
2	Diabetes
1	Eczema
1	Edema
1	Bronchitis
1	Herpes
1	Tuberculosis
1	Heart murmur
1	Sickle Cell Disease
1	Seizure disorder
1	Syphilis
1	Not documented

Other psychosocial and environmental problems and problems with primary support group were the most frequently documented Axis 4 diagnoses.

Frequencies of Axis 4 diagnoses

#	Axis 4 Diagnosis
16	Not documented
15	Other psychosocial and environmental problems
14	Problems with primary support group
10	Problems related to the social environment
10	Housing problems
8	Economic problems
7	Occupational problems

6	Missing/Not abstracted
1	Educational problems
1	Problems with access to health care services
0	Problems related to interaction with the legal system/crime

BCHD Quality Improvement Project
Mental Health Services: Adult
Client Chart Abstraction

Instructions

Complete this instrument for clients older than 18 years at time of intake. (For clients 18 years or less at time of intake, use the Mental Health Services: Children and Adolescents Client Chart Abstraction instrument.)

Section 1. Reviewer Information

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry in client chart)	
1.8	Chart end date (Date of last entry in client chart)	
1.9	Dates of services reviewed in chart	☐ 3/1/01 to 2/28/02 (Default) ___ / ___ / _____ to ___ / ___ / _____
1.10	Was chart **opened/mental health services initiated** during review period?	☐ Yes ☐ No; mental health services initiated prior to review period ☐ Not documented in chart
1.11	Was **chart closed/client terminated** from mental health services during review period?	☐ Yes ☐ No; client continued to receive mental health services throughout review period ☐ Not documented in chart

Section 2. Client Demographics

Instructions: Provide the requested information based on information contained in the client's chart.

2.1	Date of birth	___ / ___ / _____ ☐ Age on 2/28/02 if no dob in chart ____ ☐ Not documented in chart
2.2	Gender	☐ Male ☐ Female ☐ Transgender ☐ Not documented in chart
2.3	Race/Ethnicity	☐ White ☐ Black/African-American ☐ Hispanic/Latino/a ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ African ☐ Caribbean ☐ Other: Specify: ☐ Not documented in chart
2.4	HIV risk factor *[Check all that apply]*	☐ Men who have sex with men (MSM) ☐ Injecting drug user (IDU) ☐ MSM and IDU ☐ Heterosexual contact ☐ Heterosexual contact and IDU ☐ Hemophilia/coagulation disease or receipt of blood products ☐ Undetermined/unknown, risk not reported ☐ Perinatal transmission ☐ Other: Specify: ☐ Not documented in chart
2.5	Zip code client residing in on 3/1/01 (or first entry In review period)	_____ City, if no zip code indicated: ☐ Not documented In chart

2.6.a	Client health insurance on 3/1/01 (or first entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

List of Maryland's HealthChoice Medicaid MCOs

AMERICAID Community Care
Helix Family Choice
Jai Medical Systems
Maryland Physicians Care
Priority Partners
United HealthCare

2.6.b	Client health insurance on 2/28/02 (or last entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

2.7.a	HIV-disease status on 3/1/01 (or first entry in review period)	☐ HIV-positive, not AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ Not documented in chart
2.7.b	HIV-disease status on 2/28/02 (or last entry in review period)	☐ Deceased Date of death: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-positive, not AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart

2.8.a	CD4/Viral Load 3/1/01 (or first entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/Specify:
2.8.b	CD4/Viral Load 2/28/02 (or last entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/Specify:
2.9.a	Client on HAART 3/1/01 (or first entry in review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/Specify:
2.9.b	Client on HAART 2/28/02 (or last entry In review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/Specify:

Section 3. Initial Evaluation

Instructions: This section is to be completed only for clients who had an initial evaluation completed during the review period—March 1, 2001 to February 28, 2002.

☐ Initial evaluation completed before to March 1, 2001 ▶ GO TO Section 4.0, page 10

☐ Client initiated mental health services after March 1, 2001 [and before February 28, 2002], but initial evaluation was not completed ▶ GO TO Section 4.0, page 10

☐ Initial evaluation completed after March 1, 2001 [and before February 28, 2002].

❶ Date of referral for services:

❷ Referral made by:

- ☐ Agency/specify:
- ☐ Self
- ☐ Family
- ☐ Criminal justice system
- ☐ Other/Specify:

☐ Source of referral not documented in chart:

❸ Date evaluation began	❹ Date completed
☐ Chart does not provide this information.	☐ Chart does not provide this information.

	Review item	Documentation
3.a	Initial evaluation must be conducted prior to the initiation of treatment. *[MH Standard1.1]*	☐ Yes, chart contains evidence that initial evaluation was completed prior to treatment initiation. ☐ Evaluation completed after treatment initiated. ☐ No evaluation was completed. ▶ GO TO Section 4.0 ☐ Other/Specify:
3.b	Initial evaluation must be conducted by licensed mental health professional working as part of an interdisciplinary team. *[MH Standard1.1]* [Check all that apply.]	What discipline(s) conducted the initial evaluation? ☐ MD, Psychiatrist ☐ MD, not psychiatrist ☐ Psychologist ☐ RN ☐ MSW/LCSW ☐ CPC/LPC-AD ☐ CAC ☐ Information not provided. ☐ Other/Specify:

3.c	Interdisciplinary team composition *[MH Standard1.1]*	❶ Does chart document care being provided by an interdisciplinary team? ☐ Yes, interdisciplinary team indicated. ☐ No, care not being provided by an interdisciplinary team. ☐ Information not provided. ❷ Is a Psychiatrist part of the service providing team? ☐ Yes, chart documents participation of psychiatrist. ☐ No, care not being provided by a psychiatrist. ☐ Information not provided. ❸ What other disciplines are part of the interdisciplinary team? [Check all that apply.] ☐ MD, Psychiatrist ☐ MD, not psychiatrist ☐ Psychologist ☐ RN ☐ MSW/LCSW ☐ CPC/LPC-AD ☐ CAC ☐ Information not provided. ☐ Other/Specify:
3.d	Initial evaluation documents client history *[MH Standard1.1.a]*	☐ Yes, chart contains evidence that evaluation documents client history. ▸ Check areas documented in client history: ☐ Chief complaint ☐ Present illness ☐ Past psychiatric history ☐ Family history ☐ Social and personal history ☐ Substance abuse history ☐ Medical history ☐ Review of systems ☐ Current and recent medications ☐ Premorbid personality ☐ No, chart does not document a client history.
3.e	Initial evaluation documents complete mental status evaluation *[MH Standard1.1.b]*	☐ Yes, chart contains evidence that evaluation documents mental status. ▸ Check areas documented in mental status evaluation: ☐ Appearance ☐ Behavior ☐ Talk ☐ Mood and affect ☐ Vital sense ☐ Self attitude ☐ Suicidal risk ☐ Homicidal risk ☐ Abnormal beliefs ☐ Perceptual disturbances ☐ Thought processes (associations, flight of ideas) ☐ Obsessions/compulsions, phobias and panic attacks ☐ No, chart does not document a mental status evaluation.

3.f	Initial evaluation documents cognitive assessment *[MH Standard1.1.c]*	☐ Yes, chart contains evidence that evaluation documents cognitive assessment. ▸ Check areas documented in cognitive assessment: ☐ Level of consciousness ☐ Orientation ☐ Memory ☐ Language ☐ Educational level and Fund of Knowledge ☐ Reasoning ability (i.e., proverb interpretation, similarities) ☐ Judgment ☐ Insight ☐ Mini-Mental Status and Verbal Trails Test ▸ Score: ☐ No, chart does not document a cognitive assessment.
3.g	Initial evaluation documents laboratory studies, as indicated. *[MH Standard1.1.d]*	☐ Yes, chart contains evidence that evaluation documents laboratory studies, as indicated. ☐ No, chart does not contain evidence that standard was met. **Check whether laboratory study was clinically indicated for patient and whether it was performed during the initial evaluation.**

Study	Indication	Performed
Blood Alcohol Level	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Toxicologies	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Liver Panel	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Renal Panel	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Thyroid Function	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
B-12/Folate	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Medication levels	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Other/Specify:	☐ Indicated ☐ Not indicated	☐ Yes ☐ No

3.h	Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation *[MH Standard1.1.e]* Axis I: Clinical disorders; other conditions that may be a focus of clinical attention Axis II: Personality disorders; mental retardation Axis III: General medical conditions Axis IV: Psychosocial and environmental problems Axis V: Global Assessment of Functioning (GAF) 100-91: Superior 90-81: Absent/minimal 80-71: Transient/expectable 70-61: Mild symptoms 60-51: Moderate symptoms 50-41: Serious symptoms 40-31: Some/major impairment in several areas 30-21: Delusions/hallucinations; inability to function in most areas 20-11: Some danger of hurting self/others; occasionally fails to maintain personal hygiene; inability to function in all areas 10-1: Persistent danger of severely hurting self or others; persistent inability to maintain personal hygiene; or serious suicidal act with clear expectation of death	❶ Does chart document a multi-axial diagnosis consistent with initial evaluation findings? ☐ Yes, chart does document a multi-axial diagnosis developed from evaluation data. ☐ No, chart does not document a multi-axial diagnosis developed from evaluation data. Documented diagnosis: Axis I: Axis II: Axis III: Axis IV: Axis V: ▸ Current GAF: ☐ GAF not documented ▸ Highest GAF in prev. 12 months: ☐ GAF not documented
3.i	Development of care plan with specific measurable treatment goals through the appropriate use of outcome assessment. The treatment plan must include input from the patient/client. *[MH Standard1.1.f]*	❶ Does chart contain a care plan developed from the data collected during the initial evaluation? ☐ No, chart does not contain a care plan developed from initial evaluation data. ▸ GO TO Section 4.0 ☐ Yes, chart contains a care plan developed from initial evaluation data. ▸ CONTINUE ❷ Does care plan contain specific, measurable treatment goals? ☐ Yes, care plan contains specific, measurable treatment goals ☐ No, care plan does not contain specific, measurable treatment goals. ❸ Does care plan contain method of outcome assessment to be used? ☐ Yes, care plan contains method of outcome assessment to be used ☐ No, care plan does not contain method of outcome assessment to be used. ❹ Does care plan address issues relating to patient's HIV-related care and/or status? ☐ Yes ☐ No *This question (3.i) continues on next page.* ⇢

	❺ Does care plan address other issues of concern to the patient (e.g., need for housing, employment, medical care?) ☐ Yes: ▶ Check how care plan addresses these issues: ☐ Care plan contains specific goals/outcomes relating to these issues for mental health services provider to address. ☐ Care plan indicates referral/collaboration with a case manager to address these issues. ☐ No, care plan addresses only the identified mental health related issues ☐ Other/Specify: ❻ Does care plan document input from the patient? ☐ Yes ▶ Check how patient input is documented: ☐ Client signed care plan. ☐ Provider's progress notes indicate discussion with patient. ☐ Other/Specify: ☐ No

3.j **Plan of care**

Specify all modalities of treatment included in the treatment plan:

a) Modality	b) Provider (Note: "by agency" refers to agency being reviewed; note external agency client was referred to, when applicable.)	c) Date Service began*	d) Check if terminated during review period/Date of termination
☐ Individual/Cognitive-Behavioral	☐ by agency ☐ by referral to:		☐
☐ Individual/Interpersonal	☐ by agency ☐ by referral to:		☐
☐ Individual/Supportive Psychotherapy	☐ by agency ☐ by referral to:		☐
☐ Individual/Psychodynamic	☐ by agency ☐ by referral to:		☐
☐ Group/ Cognitive-Behavioral	☐ by agency ☐ by referral to:		☐
☐ Group/Psychoeducational	☐ by agency ☐ by referral to:		☐
☐ Group/Supportive	☐ by agency ☐ by referral to:		☐
☐ Other/Specify	☐ by agency ☐ by referral to:		☐

*If service was not provided, then write "NOT PROVIDED"; note reason service was not provided, if documented.

3.k Plan of care is consistent with practice guidelines *[MH Standard1.1.g]*	Does treatment plan adhere to recognized treatment guidelines for the diagnosis category being treated? ☐ Yes ☐ No ▶ Specify how the plan of care is not consistent with guidelines?

Section 4. Provision of Services

Instructions: This section is to be completed for all clients. Instructions: Review only documentation of services provided during the review period, March 1, 2001 to February 28, 2002.

▶ This section is to be completed for all clients

4.a	Care plan	Does chart contain a care plan for the client? ☐ Yes, chart contains a care plan. ☐ No, chart does not contain a care plan. ☐ Other/Specify:
4.b	Documentation of frequency of visits *[MH Standard 1.2.a]*	❶ Does chart contain documentation of patient visits? ☐ Yes, chart **does** contain documentation of patient visits. (e.g., Progress Notes/encounter data for each patient visit to provider.) ☐ No, chart d**oes not** contain documentation of patient visits. ❷ Does chart contain documentation of visit frequency that is appropriate, based on the diagnosis, severity of need and treatment plan? (e.g., if condition is not yet stable, are appointments documented every 1 to 2 weeks; are medications being monitored every 3 months). ☐ Yes, chart **does** contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan. ☐ No, chart **does** not contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan.
4.c	Documentation of provision of supportive and educational counseling at all visits. "This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse." *[MH Standard 1.2.b]*	❶ Supportive and educational counseling ☐ Yes, chart **does** contain documentation of provision of supportive and educational counseling on each visit. ☐ No, chart **does not** contain documentation of provision of supportive and educational counseling on each visit. ❷ HIV Prevention counseling ☐ Yes, chart **does** contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors." ☐ No, chart **does not** contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors." ❸ Substance abuse counseling ☐ Yes, chart **does** contain documentation of provision counseling regarding "substance abuse." ☐ No, chart **does not** contain documentation of provision counseling regarding "substance abuse."
4.d	Documentation of monitoring of medications *[MH Standard 1.2.d]*	❶ Are medications prescribed by the mental health provider? ☐ No. ▶ GO TO 4.f, below ☐ Yes ❷ Are the medications prescribed by: ☐ Physician ☐ Physician Assistant ☐ Psychiatrist ☐ Other/Specify: ☐ Nurse Practitioner ☐ Information not provided. *This question (4.d) continues on next page.* ⇢

		❸ Are medications prescribed by the mental health provider clinically appropriate and indicated by treatment guidelines? ☐ Yes ☐ No ❹ Does chart contain documentation of routine and appropriate monitoring of medications under the supervision of a psychiatrist? ☐ Yes ▸ Indicate methods used (check all that apply): ☐ Laboratory monitoring ☐ Patient interview ☐ Caregiver interview ☐ Patient survey completed ☐ Other/Specify: ☐ No ❺ Does chart contain documentation that patient has the opportunity to develop ongoing relationships with the psychiatrist prescribing medications? ☐ Yes, chart documents opportunity for patient to develop relationship. ☐ No, chart does not document opportunity for patient to develop relationship. ☐ Not applicable/Other:
4.e	Documentation of assessment of medication side-effects and patient teaching *[MH Standard 1.2.e]*	❶ Does chart contain documentation of routine and appropriate side-effect assessment? ☐ Yes ▸ Indicate methods used (check all that apply): ☐ Laboratory monitoring ☐ Patient interview ☐ Caregiver interview ☐ Patient physical assessment ☐ Other/Specify: ☐ No ❷ Does chart contain documentation of routine and appropriate teaching patient about medications? ☐ Yes ▸ Indicate methods used (check all that apply): ☐ 1:1 teaching by health care team. ☐ Materials given to patient. ☐ Referring patient to educator or group sessions. ☐ Other/Specify: ▸ Indicate content documented (check all that apply): ☐ Expected benefit of medications. ☐ Common and potentially serious side-effects of medications. ☐ Importance of medication adherence. ☐ No ☐ Other/Specify:
4.f	Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment outcome assessment.	❶ Does the chart document objective progress toward treatment goals? ☐ Yes, chart does contain documentation of objective progress. ☐ No, chart does not document progress. *This question (4.f) continues on next page.* ⇢

	Inclusion of patient in monitoring. *[MH Standard 1.2.f]*	❷ Is the client making progress toward treatment goal attainment? ☐ Yes, provider indicates that client is making progress. ☐ No, provider indicates that client is not making progress. ▸ Indicate barrier(s) to progress identified by provider (check all that apply): ☐ Non-adherence with medication/treatment ☐ Lack of medication tolerability or medication adverse effects ☐ Inadequate dosage/need to adjust dosage ☐ Change in patient stressors ☐ Medical co-morbidity ☐ Other/Specify: ☐ Chart does not document reasons for lack of progress. ❸ Does chart contain documentation of patient inclusion in monitoring/assessment? ☐ Yes. Chart **does** contain documentation of patient inclusion in monitoring assessment. ☐ No. Chart **does not** contain documentation of patient inclusion in monitoring assessment.
4.g	Documentation of care plan reassessment at least every three months. *[MH Standard 1.2.g]*	❶ Does chart contain a care plan for the client? ☐ **No,** chart does not contain a care plan. ▸ GO TO 4.h ☐ **Yes,** chart contains a care plan. Number of months of service provision during review period: (March 1, 2001 to February 28, 2002) ____ Number of reassessments documented: ____ ❷ Does chart contain documentation that care plan was reassessed at least every three months during the period of service provision? ☐ **No,** chart does not contain any documentation of reassessment. ▸ GO TO 4.h ☐ **Not applicable:** Client received services less than three months, so a reassessment was not indicated. ▸ ☐ Check here, if treatment plan was reassessed during the first three months of service provision. ▸ GO TO 4.h ☐ **Yes,** chart contains documentation of reassessment. ▸ CONTINUE ❸ Based on the documentation in the chart, should the reassessment of the care plan have led to development of new goals/objectives/ outcomes? ☐ **Yes**, care plan content needed to be updated based on the documentation in the client chart. ▸ Was care plan? ☐ Appropriately updated; new goals/objectives outcomes established as indicated. ☐ Not updated as indicated. ☐ **No,** initial/previous care plan content was still appropriate.

4.h	Discharge planning/continuity of care	❶ Did client complete/was terminated from a mental health services during the review period? ☐ No. Client continued to receive services. ■ END OF CHART REVIEW ☐ Information not provided. ■ END OF CHART REVIEW ☐ Yes. Client completed/was terminated. ▶ ☐ Client completed treatment services. ☐ Client was terminated from treatment services. ▶▶ State reason for termination: ☐ Reason for termination not documented. ❷ Does chart contain documentation of appropriate discharge planning for client? ☐ Yes ☐ No ❸ Does chart contain documentation of inclusion of client in discharge planning? ☐ Yes ☐ No ❹ Does chart contain documentation of adequate follow-up/aftercare/ contingencies? ☐ Yes ☐ No ❺ Does chart contain documentation of appropriate referrals to primary care? ☐ Yes ☐ No ☐ Not applicable: Client already successfully linked to primary care. ❻ Does chart contain documentation of appropriate referrals to case management? ☐ Yes ☐ No ☐ Not applicable: Client already successfully linked to case management ❼ Does chart contain documentation of appropriate referrals to ancillary care? ☐ Yes ☐ No ☐ Not applicable. Referrals not indicated.

BCHD Quality Improvement Project
Mental Health Services: Adult
Agency Survey

- Agency Name:
- Address:
- Person completing form:
- Telephone:
- Fax:
- E-mail:

Please check all of the services that your agency **directly provided,** on-site during Title I fiscal year 2001 (March 1, 2001-February 28, 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Outreach
- ☐ Substance Abuse Treatment
  - ☐ Inpatient Detoxification
  - ☐ Outpatient Detoxification
  - ☐ Long-term Structured Program
  - ☐ LAMM
  - ☐ Methadone
  - ☐ 12-step Programs
  - ☐ Individual counseling
  - ☐ Other_____
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Case Management Adherence
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Please check all of the services that your agency does not directly provide on-site, but have **established (written) referral agreements** with other agencies to provide these services to your clients during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Outreach
- ☐ Substance Abuse Treatment
  - ☐ Inpatient Detoxification
  - ☐ Outpatient Detoxification
  - ☐ Long-term Structured Program
  - ☐ LAMM
  - ☐ Methadone
  - ☐ 12-step Programs
  - ☐ Individual counseling
  - ☐ Other_____
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Mental Health Services
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Standards of Care

A. Licensing, Knowledge, Skills and Experience

1. Do all staff involved in the delivery of mental health services have the appropriate and current professional licensure from the state of Maryland?
   ☐ Yes ☐ No

2. Do all non-licensed staff and trainees delivering mental health services receive professional supervision by licensed mental health providers?

   ☐ Yes ☐ No

3. Do all mental health treatment staff have either specific experience in caring for HIV-infected patients or receive appropriate training?

   ☐ Yes ☐ No

4. Are mental health treatment providers encouraged to develop the expertise needed to provide the specialized care that HIV-infected patients need?

   ☐ Yes ☐ No

- If Yes, describe how this is achieved?

5. If unlicensed providers will be providing services, has a formal letter of collaboration been established that outlines the nature and type of supervision received by specific licensed providers?

   ☐ Yes ☐ No

B. Patient Rights and Confidentiality

6. Does the agency have written policies and procedures that assure patient confidentiality (In accordance with Maryland Annotated Code) with regard to transmission, maintenance and security of medical information?

   ☐ Yes ☐ No

7. Does the agency have written policies and procedures regarding the provision of culturally appropriate care to their patients?

   ☐ Yes ☐ No

8. Do all mental health treatment staff have experience caring for or training working with the following groups:

   ☐ Yes ☐ No Men having sex with men
   ☐ Yes ☐ No African-Americans
   ☐ Yes ☐ No Persons with substance abuse history

9. Does the agency have written policies and procedures regarding:

   ☐ Yes ☐ No Confidentiality
   ☐ Yes ☐ No Equal access to care
   ☐ Yes ☐ No Provision of service regardless of sexual orientation

C. Access, Care and Provider Continuity

10. Upon notification of the provider, emergencies are addressed in:

☐ Less than 1 hour
☐ 1-2 hours
☐ 3-4 hours
☐ 5 hours or more

11. New patient evaluations are generally conducted within:

☐ The same day as the referral
☐ 5 days or less
☐ 6-10 days
☐ Greater than 10 days

12. Has the agency considered providing access to staff on a 24-hour basis?

☐ Yes ☐ No

▸ If Yes, Is 24-hour access to staff now available?

☐ Yes ☐ No

▸ If 24-hour access is not available, describe the reasons why this has not been implemented.

13. Does the agency have mechanisms in place for urgent care evaluation and/or triage?

☐ Yes ☐ No

▸ If Yes, describe these mechanisms.

14. Does the agency have mechanisms in place to facilitate access to the following services If needed:

☐ Yes ☐ No Day programs
☐ Yes ☐ No Day hospitals
☐ Yes ☐ No Inpatient psychiatric units

▸ If Yes, describe these mechanisms.

15. Does the agency have mechanisms in place to ensure continuity of mental health/psychiatric care to their patients when the clients are in the following care settings:

☐ Yes ☐ No Day programs
☐ Yes ☐ No Day hospitals
☐ Yes ☐ No Substance abuse programs
☐ Yes ☐ No Inpatient psychiatric units
☐ Yes ☐ No Inpatient medical units
☐ Yes ☐ No Chronic care units (nursing homes)

▸ If Yes, describe these mechanisms.

16. Have provisions been made for "off-site" care if clinically necessary?

☐ Yes ☐ No

▸ If Yes, describe these mechanisms.

17. Has the agency developed and maintained linkages with substance abuse treatment providers to maintain care continuity for patients with substance use and other mental health disorders?

☐ Yes ☐ No

▸ If Yes, describe these mechanisms.

18. Has the agency developed and maintained formal memorandum of understanding/agreement to ensure care continuity with:

☐ Yes ☐ No Primary care providers
☐ Yes ☐ No Specialty medical care providers

D. Quality Improvement

19. Does the agency have an on-going quality improvement/quality assurance program for mental health services that identifies areas for improvement and subsequent actions taken?

☐ Yes ☐ No

20. Are utilization review decisions based on best practice and consistent with established treatment guidelines?

☐ Yes ☐ No

21. Does the agency have a process for clients to evaluate the agency, staff and services?

☐ Yes ☐ No

- If Yes, describe this process.

OPERATIONAL & PERFORMANCE STANDARDS FOR MENTAL HEALTH PROVIDERS

ratified: October, 1997; reviewed September 1999.

STANDARD OF CARE 1.0

Mental health and psychiatric care for persons with HIV disease should reflect competence and experience in evaluation, formulation, and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

The following components of evaluation and treatment should be standard practice with all patients/clients and be reflected in medical record documentation:

1.1 AN INITIAL EVALUATION MUST BE CONDUCTED PRIOR TO THE INITIATION OF ANY TREATMENT. THIS EVALUATION MUST BE CONDUCTED BY A LICENSED MENTAL HEALTH PROFESSIONAL WORKING AS PART OF AN INTERDISCIPLINARY TEAM. THIS TEAM MUST CONSIST, AT A MINIMUM OF: A PSYCHIATRIST AND ANY OF The FOLLOWING PROFESSIONALS: A PSYCHOLOGIST AND/OR A SOCIAL WORKER AND/OR A MENTAL HEALTH CLINICAL SPECIALIST NURSE . NON-LICENSED PROVIDERS MAY ALSO PROVIDE SERVICES UNDER THE SUPERVISION OF APPROPRIATELY LICENSED PROVIDERS. THE EVALUATION MUST CONSIST OF THE FOLLOWING:

a. History: chief complaint, present illness, past psychiatric history, family history, social and personal history, substance use history, medical history, review of systems, current and recent medications, and premorbid personality.
b. Complete mental status evaluation: appearance and behavior, talk, mood, vital sense, self attitude, suicidal risk, homicidal risk, abnormal beliefs (delusions, overvalued ideas), perceptual disturbances (hallucinations, illusions), obsessions/compulsions, phobias, panic attacks.
c. Cognitive assessment: level of consciousness, orientation, memory, language, praxis, executive (may substitute the Mini-Mental State and Verbal Trails Test).
d. Laboratory assessment, as clinically indicated.
e. Multi-axial differential diagnosis leading to final diagnostic formulation.
f. A plan of care with specific measurable treatment goals through the use of appropriate outcome assessment. The treatment plan must include input from the patient/client.
g. Practice guidelines for specific conditions/situations/disorders, such as those published by the American Psychiatric Association or the American Psychological Association, should inform the treatment plans.

1.2 FOLLOW-UP VISITS TO PROVIDE OR MONITOR TREATMENTS AND TO ASSESS PROGRESS TOWARD MEETING CARE PLAN GOALS

a. Visit frequency averaging every week to two weeks for patients with active symptoms working toward a short-term goal. For those whose symptoms are in remission but remain on psychotropic medicines, visits averaging every three months are necessary.
b. The provision of supportive, and educational counseling, at all visits. This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse, as clinically indicated.

c. The provision of specific types of psychotherapy (e.g. interpersonal, behavioral, psychodynamic, cognitive) individual, group or family as indicated by the clinical situation, based on practice guideline recommendations, and linked to specific treatment goals.

d. The prescription and monitoring of appropriate psychotropic medications as indicated by the clinical situation, evidence-based practice guideline recommendations, and linked to specific treatment goals. Psychotropic medications must be provided under the supervision of a psychiatrist. Patients/clients must have the opportunity to develop ongoing relationships with the psychiatrist(s) prescribing their psychotropic medication(s).

e. Medication side affect assessment and teaching for patients on psychotropic medications.

f. Monitoring of progress toward care plan goals through the use of appropriate outcome assessment, which must include input from the patient/client.

g. Reassessment of each patient/client's case and care plan at least every three months.

STANDARD OF CARE 2.0

HIV mental health providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness, and continuity of care; and (d) quality of care improvement efforts,

2.1 LICENSING. KNOWLEDGE, SKILLS, AND EXPERIENCE

a. All staff delivering mental health services will possess current organizational and professional licensure.

b. Non-licensed staff or trainees delivering mental health services will receive professional supervision, of the care they are providing to individual patients/clients, by a licensed mental health provider.

c. All staff delivering mental health services will either have specific experience in caring for HIV infected patients or receive appropriate training.

2.2 PATIENT RIGHTS AND CONFIDENTIALITY

a. The provider organization will provide assurances and a method of protection of patient rights in the process of care provision.

b. The provider organization will provide assurances and a method of protection of patient confidentiality (in accordance with Maryland Annotated Code), with regard to medical information transmission, maintenance and security.

c. The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients/clients. Specifically, the providers must have training or experience with caring for those groups most affected by the epidemic, such as gay men, African-Americans, and substance abusing persons.

d. The provider organization will provide assurances that mental health treatment services will be provided regardless of the sexual orientation of the client/patient. Respect, confidentiality, and equal access will be assured.

e. If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific licensed providers.

2.3 ACCESS, CARE AND PROVIDER CONTINUITY

a. The provider organization will provide clinical services in a timely fashion to all patients/clients. Emergencies must be addressed within 2 hours of notification of the provider. New patient/client evaluations will generally be conducted within 10 working days of notification of the provider. Providers must consider providing access to their staff on a 24-hour basis.
b. The provider organization must provide mechanisms for urgent care evaluation or triage.
c. The provider organization will provide mechanisms to make available to its patients/clients access, if clinically indicated, to the full range of mental health treatment settings including day programs, day hospitals, and inpatient psychiatric units.
d. The provider organization will provide mechanisms for continuity of mental health/psychiatric care to their patients/clients in all settings in which they may receive care, including by limited to day programs, day hospitals, substance abuse programs, inpatient psychiatric units inpatient medical units, and chronic care units (nursing homes). Provision will be made for "off site" care if clinically necessary.
e. The provider organization will develop and maintain linkages with substance abuse treatment service providers, so as to maintain care continuity for patients with dual diagnoses of substance use disorders and other mental disorders.
f. The provider organization will develop and maintain linkages with primary medical care service providers, so as to maintain care continuity for patients receiving primary or specialty medical care.

2.4 QUALITY IMPROVEMENT

a. The provider organization will provide for methods to monitor for areas in need of improvement.
b. The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement.
c. Utilization review decisions will be clinically based on best practice and consistent with emerging national standards.